Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: SOUTH COAST REHABILITATION PA P O BOX 3110 BROWNSVILLE TX 78523-3110	MFDR Tracking #: M4-09-6090-01
	DWC Claim #:
	Injured Employee:
	Date of Injury:
Respondent Name and Box #: INDEMNITY COMPANY OF NORTH AMERICA Box #: 15	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: As taken from the requestor's request for reconsideration. "The only modifier that was used was for CPT Code 97139-SS. All other CPT Codes do not have modifiers. Date of service 7/30/08 and 8/28/08-No TWCC-62 forms were are enclosed behind this section because no Explanation of Benefits (TWCC-62) forms were received. Enclosed is convincing evidence that the carrier did receive our complete medical bills…"

Amount in Dispute: $3,376.20

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: As taken from the table of disputed services, "Did not submit the proper modifiers per Medicare Guidelines Rule 134.202(b). Rule 134.203 (a)(5)…" Position summary for dates of service 8/13 and 8/19/08, "pd in error."

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
07/22/2008 thru 08/28/2008	97035, 97032, 97124, 97139-SS, 97113, 97110	N/A	$3,298.06	$-0-
07/30/2008	99213	($52.83 WC CF ÷ 38.087 MC CF) x $56.34 Participating Amount = $78.14 MAR – $49.58 Respondent Reimbursement = $28.56	$78.14	$28.56
			Total Due:	$28.56

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 effective May 25, 2008, sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.20 sets out Medical Bill Submission by the Health Care Provider.
3. 28 Tex. Admin. Code §134.203 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of Benefits dated 8/20/2008, 9/08/08, 9/10/08, 9/18/08

   - 45 – Charges exceed your contracted/legislated fee arrangement. The charges have been priced in accordance

with your fee for service contract with First Health.

- 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing. Reimbursement is made based on coding, billing and reimbursement methodologies.

Reconsideration Explanation of Benefits dated 11/05/08, 11/06/08,

- Reimbursement for this procedure was withheld due to previous submission on 8/20/08.
- 45 – Charges exceed your contracted/legislated fee arrangement. The charges have been priced in accordance with your fee for service contract with First Health.
- W3 – Addl pymt made on appeal/reconsideration. Reimbursement is based on balance due from a previously submitted invoice.

Issues

1. Was the CMS-1500 for date of service 08/28/2008, submitted to the respondent in accordance with 133.20? Did the requestor bill for the dates of services in dispute in accordance with 28 Tex. Admin. Code §134.203(b)(1)?
2. Was there a PPO contract between South Coast Spine and Rehabilitation and First Health Group Corp.?
3. Is the requestor entitled to reimbursement?

Findings

1. Neither the requestor nor the respondent submitted EOBs for date of service 08/28/2008. The requestor submitted a USPS priority mail receipt with a ship date of 10/16/2008 to show they sent the bill to the respondent in accordance with 28 Tex. Admin. Code 133.20. Therefore, this CPT code will be reviewed in accordance with 28 Tex. Admin. Code 134.203. 28 Tex. Admin. Code §134.203 states in pertinent part, "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health care professional shortage areas (HPSAs) and physician scarcity area (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules." The TrailBlazer Chiropractic Services Manual states, "CHIROPRACTORS BILLIING FOR PHYSICAL THERAPY Chiropractors billing for physical therapy services (CPT codes 97001-97799 and HCPCS code G0283) must bill with the appropriate modifier. GN – Services delivered under an outpatient speech-language pathology plan of care. GO – Services delivered under an outpatient occupational therapy plan of care. GP – Services delivered under an outpatient physical therapy plan of care." According to the CMS Claims Processing Manual Pub. 100-04 20 – HCPCS Coding Requirements, the disputed codes are considered "always therapy" services, regardless of who performs them. These codes always require therapy modifiers (GP, GO, GN). In dispute are CPT codes 97035, 97032, 97124, 97139-SS, 97113, and 97110 billed by a Chiropractor. The disputed codes were not billed with the required modifiers.
2. Also in dispute is CPT code 99213 for date of service 07/30/2008. The requestor submitted with their dispute packet a reconsideration EOB dated 11/05/2008. At the request of Medical Fee Dispute Resolution (MFDR), the respondent supplied the initial EOB dated 08/20/2008. According to this EOB, the respondent issued payment for CPT code 99213 in the amount of $49.58 which included a PPO reduction. According to the explanation of benefits, the services in dispute were paid using a contracted fee arrangement. Tex. Labor Code Ann. §413.011(d-3) states that the division may request copies of each contract under which fees are being paid, and goes on to state that the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract is not provided in a timely manner to the division. On 11/02/2010, the Division requested a copy of the contract between the network and the health care provider. The carrier provided a copy of the requested documentation on 11/05/2010. However, the contract was executed between Equilibrium, L.L.C. Federal Tax I.D. number 03-0412776 and First Health Group Corp. The health care provider in this dispute is South Coast Spine and Rehabilitation with Federal Tax I.D. number 20-0843700. The respondent has not provided sufficient documentation to support that a contract between South Coast Spine and Rehabilitation and First Health Group Corp. existed. For this reason, CPT code 99213 will be reviewed in accordance with 28 TAC. §134.203. Documentation supports the service rendered.
3. The requestor is not entitled to reimbursement for CPT codes 97035, 97032, 97124, 97139-SS, 97113, and 97110. The requestor is entitled to additional reimbursement for CPT code 99213.

Conclusion

For the reasons stated above, the division finds that the requestor is entitled to additional reimbursement for CPT code 99213. As a result, the amount ordered is $28.56.

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PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of $28.56 plus applicable accrued interest per Division rule at 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature	Medical Fee Dispute Resolution Officer	May 18, 2011 Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.